# Successful Management of Non-Diagnosed Placenta Percreta during Dilatation & Extraction Surgery

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**ABSTRACT**

Placenta accreta is the most complicated and life-threatening hemorrhage. Although ultrasound evaluation is important, the absence of ultrasound findings does not preclude a diagnosis of placenta accreta spectrum; thus, clinical risk factors remain equally important as predictors of placenta accreta spectrum by ultrasound findings

We report one case of cesarean hysterectomy in patient with placenta accreta.

**Keywords:** Management, Non-Diagnosed, Placenta Percreta, during Dilatation, Extraction.

## INTRODUCTION

Hemorrhage during pregnancy or after delivery is one of the most common causes of maternal mortality and morbidity (1). Among all obstetric complications, we might be able to say that placenta accreta is the most complicated and maternal life-threatening situation which can cause massive hemorrhage if it is not investigated properly and on time. Placenta accreta is a condition in which placenta invade the uterine wall and reach the myometrium. Depending on its level of invasion, it will be divided into three groups as follows:

1- Placenta accreta vera: this is the most common and benign condition in which placenta penetrates endometrium adhere to the surface of uterus myometrium.
2- Placenta increta: this type of placenta will adhere to the body of myometrium, but it will not penetrate into the full thickness.
3- Placenta percreta: this is the most complicated and uncommon type of the placenta accreta. In this type, placenta penetrates into myometrium and uterus wall and sometimes, neighbor organs like bladder.

Diagnosis of placenta accreta is very controversial and there has been some debate about the best time for running diagnostic test. Abdominal and transvaginal sonography are the most accurate tests, also we can use magnetic resonance imaging when we are suspicious of the accuracy of sonographic imaging or we want to double check our diagnosis; but there is not any certain evidence about superiority of magnetic resonance imaging in diagnosis of placenta accreta. Although, in many cases placenta accreta remains undiagnosed just until the delivery time and attempting to separate the placenta can result in massive hemorrhage after diagnosis of placenta accreta, patient should go under surgery and in most cases hysterectomy is necessary to save mothers' life (2).

There are certain risk factors for placenta accreta and among them, the most common risk factor is cesarean section. Other risk factors includes previous uterine surgery, placenta previa, grand multiparity and maternal age (3).

More frequent risk factor for placenta accreta is uterine damage; the more uterine is damaged, the higher is the risk of placenta accreta. Nowadays, the incidence of placenta accreta has increased because of the growth in popularity of cesarean section surgery. Here, we are presenting a case of placenta percreta, in which the patient had been diagnosed when she was under the procedure of dilatation and extraction (4).

## RESULTS

A 37 years old pregnant woman was admitted to the Alborz hospital with chief complaint of vaginal leakage. Her gestational age according to her LMP was 13 weeks and sonographic investigation showed 15 weeks of pregnancy. She also gave a history of two previous live births which were performed by C-section. She did not have any history of abortions.

Primary investigations were presenting a premature rupture of membrane with amniotic fluid index of 16 mm, which indicated a severe oligohydramnios condition. Sonographic studies also showed a fetal heart rate of

143bpm; therefore, the patient referred to Kamali center of obstetrics and gynecology. In Kamali hospital, PROM were confirmed and initial arrangements and tests were performed. There was no abnormality in her hemodynamic and biochemistry tests. Therefore, the patient were planned for abortions and admitted with misoprostol (9).

After 2 weeks of receiving misoprostol, the fetus was still observable in uterus with a normal heart rate. In this station, there was doubt about placenta accrete, so the patient was admitted to sonologist in order to rule out placenta accreta. Unfortunately, primary investigations did not approve placenta accreta, so the patient was admitted to operation room for dilatation and extraction surgery and removing the fetus manually. After spinal anesthesia, D & E were started. There were some complications in removal of fetal body, but finally after so many attempts all body parts were removed. Even though the body was removed, we could not find the placenta. So many attempts occurred but no result was obtained except massive hemorrhage and omentom pulled out from vagina. At this point, we were certain that the uterus is perforated and major concern was about the damage to large intestine. Therefore, plan changed to hysterectomy and full surgical investigation of intestine in order to treat any probable damages. A general surgeon immediately was called and 4-pack cell was reserved. During the observation and investigation of uterus placenta percreta were detected. Therefore, we also called for an urologist, because involvement of bladder in this situation is very common.

Finally, after 2 hours of surgery with a team of four surgeon, we were managed to stop the bleeding and removed the uterus successfully.

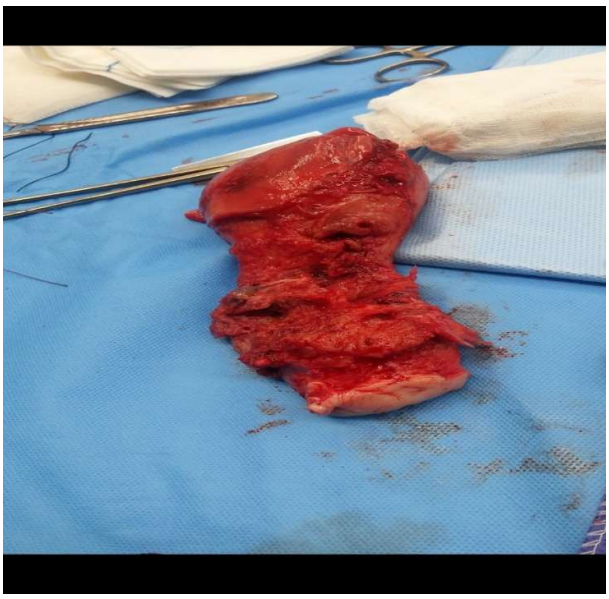

**Figure 1.** placenta accreta in the 13-15 week pregnant uterus

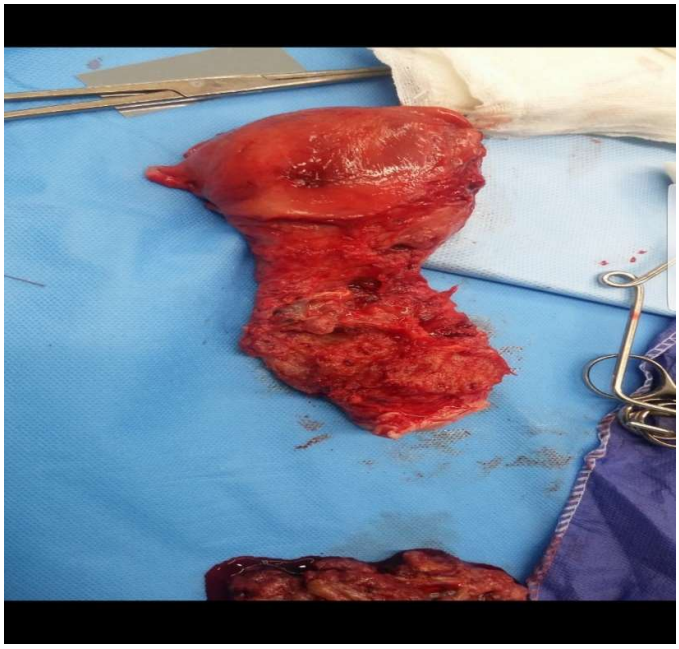

**Figure 2.** placenta accreta in the 13-15 week pregnant uterus

**DISCUSSION & CONCLUSION**

One of the most debut full subjects in cases of placenta accreta is diagnosing it on time and before starting of delivery process or occasion such as what we described. In this case, placenta accreta remained undiagnosed just until we directly observed it during process of hysterectomy (5).

Another subject, which we should consider in diagnosing placenta accreta, is the sensitivity and specificity of sonographic investigations in each trimester. According to a research which was done by RAHIMI-SHARBAF et al., (6) on 323 high risk patients, the sensitivity and specificity of sonographic investigations in the second trimester were 60% and 83.5%, respectively. Given the low accuracy of sonographic investigations in this trimester alone, the outbreak of placenta percreta in second trimester is not so high, therefore, it will be at lower place in differential diagnosis lists (7, 8).

We can conclude two things from this case report: first is that in all trimester we should suspect the occurrence of placenta accreta and more specifically placenta percreta. As we mentioned before, the sonographic investigations may not detect placenta accreta so we should not rely on them, especially in crowded centers like our center that the accuracy of sonographies is even lower according to their condition. In these cases, we should rely on past medical history of the patients and considering if they meet the risk factors criteria. The second things is that in repeated cesarean sections, the risk of occurrence of placenta accreta and percreta will be higher, so we should avoid this surgery as much as we can (9).

Also, it is very important to bear in mind that if the fetus was at near delivery stage or access to reliable sources for surgery such as expert surgeon or enough of blood supply were limited, there is no doubt about the mortality of mother. We suggest that the investigation of placenta accreta should not be only based on radiological examinations because especially in early weeks it might remain undetected. It shows us that there is certain need of supplementary tests to prevent such occasions (10).

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